Community Counseling Center
of Central Florida, LLC
Physical Address:3544 Edgewater Drive, Orlando, FL 32804-2922
Mailing Address: PO BOX 161585, Altamonte Springs, FL 32716-1585
W. 407.291.8009
F. 407.770.5503
www.ccccf.org
NPI #1902886781
EIN # 56-2463919

Good Faith Estimate for Health Care Items and Services

Date of Good Faith Estimate: 08-14-24

The estimated cost(s) are valid for 12 months from the date of the Good Faith Estimate.

Client Name Corrie Tester
Client DOB 10-12-2008
Client MR # 0010035
Client Email Address testercapture@gmail.com
Payment Source TANF
DSM 5 Diagnostic Code: Pending intake assessment if completed.

Please note if you are using the following funding sources the cost to you will be **ZERO DOLLARS** for services rendered. You may be asked to pay the agreed upon amount of a no-show fee for not keeping appointments (exception Medicaid) and you will sign a separate document for that specified agreed upon fee (by you the client and the therapist you are working with).

This document is being provided to all clients/potential clients in the spirit of transparency.

- Sunshine Medicaid
- CMS Medicaid
- TANF
- Family Partnerships of Central Florida
- Victim's Compensation
- Statewide Community Based Counseling (CBC) Funds (i.e. ChildNet)
- Orange County Breakthrough Program
- Seminole County Sheriff's Office Mobile Crisis Services

The intention of the Good Faith Estimate is for those paying CCCCF cash/money order for their treatment (private pay) and not utilizing any of the above funding sources. Payment is expected at the time the service is rendered (or before) and generally speaking a bill is only sent if payment delinquency becomes an issue. Receipts for payment are provided upon request.

Primary Service or Item Requested/To Be Scheduled:
- Parent Education Course $150
- Anger Management Course $150
- Mental Health Assessment $150
- Intake Assessment for Therapy (individual/family) $150
- Individual Therapy Session per hour: $95 (PhD) or $75 (LMHC/LMFT) or $60 (Registered Intern/Master's Level Student Intern).

Disclaimer:
This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill. If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call HHS PHONE NUMBER 1-877-696-6775*.*
For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-877-696-6775.

HHS Headquarters Mailing Address and Telephone Number
The U.S. Department of Health & Human Services
Hubert H. Humphrey Building

200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free Call Center: 1-877-696-6775

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount

Respectfully submitted,

Corrie L. Kindyl, Ph.D., LMHC, LMFT, NCC, ACS, Qualified Supervisor

Corrie Kindyl, Ph.D., LMHC, LMFT, NCC, ACS, Qualified Supervisor
CEO

I, **Corrie Tester,** consent to the statements made above.
(Client/Legal Representative)

X____

Date: ____________________________________